Vol. II

of 320 milligrams?
A. It's hard to explain. 320 and 320 would be the same as 40 and 40, 80 and 80, 160 and 160, 320 and 320.
So, it's the same At. mixture. What she was running it at would have been what the patient received, not what she mixed it in.
Q. But did she mix it in a higher quantity than what the patient was receiving?
A. Oh, she mixed it in a higher quantity than is policy. That's the way I would say it. She mixed it in a higher quantity than we normally do.
Q. All right. And what was your understanding as to what the policy was?
A. To be honest with you, at that point, I was not sure how we did it.
And I asked Kathy Hutchins, who is our clinical specialist, who you've already heard from.
And she said that normally, 80/80 sometimes. 160/160, if it's a very -- if it's a person that's going to go through a lot of Ativan in a shift.

Q. Okay. Now, what did Nancy Dufault tell you?
A. She told me she had mixed it 320 and 320.
Q. Okay. And what did you tell her?
A. I told her -- at that time, I had not talked to Kathy.
I told her, at that time, that it sounded high to me. The mixture sounded high. And that she should just refer to the policy, and run it at that, even if it meant she would have to change it quite frequently during the night.
Q. Now, did anything else come of this incident?
A. No.
Q. And why didn't you do anything else?
A. I felt really comfortable with her answer. She had been a nurse a very long time in the ICU. There was no reason to believe anything else.
And the patient was receiving a lot of narcotic. And we do, often times, quadruple a drip, even though 320/320 is even higher than a quadruple.

Q. Now, later in the summer, did a problem regarding Nancy Dufault come to your attention again?
A. Yes. Again, at the end of July, Cindy came to me again, and said, again, she was reviewing the record, the Omnicell reports. And she had found a couple of Omnicell reports that stuck out in her mind for the doses and the times.
It was a large amount of doses in very short periods of time. Like, minutes. One minute apart. There were large doses taken out, mostly Ativan.
And she was concerned about the amounts that were taken out.
Q. Okay. And what did you do then?
A. Well, then, I thought, "Well, this is the second time she's come to me. We should probably look into it a little bit deeper."
So, I asked Cindy to do a -- I wouldn't call it an investigation. I asked her to look into some medical records for us, and see, for the patients that she was identifying, exactly what kind of documentation there was on

that.
Q. Okay. And did you have any role in procuring any records with respect to this at that time?
A. Do you mean by procure, did I call and ask for them?
Q. Call and what?
A. Ask for them.
Q. Yes.
A. Yes. I'm the one that called medical records and asked that they be pulled.
Q. Okay. And what about the pharmacy?
A. And I called pharmacy, and asked them to -- well, I did that first. I called pharmacy, and asked them to run a report, so that I would know which ones to pick from, and then gave that list to medical records, so that I could get the records.
Q. Okay. And did someone then go through all those records?
A. Cindy did.
Q. Mm-hmm. And during what period of time was Cindy doing this?
A. Cindy did that in the beginning of

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August. By the time we got the charts, got the Omnicell reports, it was the beginning of August.

So, I would say middle of August, maybe, by the time she started really getting into it.

Q. And at some point, did Cindy come back to you with any results or finding?

A. Yes. She had written her findings down on a piece of paper for me that were kind of awe-striking.

A lot of drugs being taken out of the Omnicell, and not being charted on the MAR, which is our med sheet.

THE ARBITRATOR: Remind me what MAR stands for.

THE WITNESS: It's our med sheet. It stands for medical administration report.

Q. (By Mr. Cahillane) And is that the computerized hospital record?

A. Yes, it is. It's SAS. Yes.

Q. Now, when Cindy presented you with this, what did you do then?

A. Well, when she came to me with these issues, it was nearing the end of August. And

like I said, it was pretty -- it was a lot of drug.

So, I went to Mary Brown. And I showed Mary Brown what we had.

And it was just a lot of drug with no MAR. And as a nurse, I know that if you're going to give a drug, you have to chart it in the MAR. And that's our policy here, at Mercy. And it's also a policy in nursing.

So, it wasn't charted. So, Cindy went and looked at the MAR. They weren't charted. There was a lot of drug not charted on the MAR.

And I went to Mary. And I said, "Mary, these drugs aren't charted, and yet they've been taken out of Omnicell, and I can't account for them."

Q. Now, was any decision made then as to what to do?

A. Mary asked me, at that point, to call Nancy, and ask her -- not to ask her -- to tell her that she was on administrative leave until we were able to further investigate the situation.

Q. Was a decision made as to how to go about a further investigation?

A. Yes. We decided that Kathy Hutchins would be the best person, because of her status here, and because of her experience.

Q. And what do you mean her status and her experience?

A. She's a clinical specialist. So, she has had training in, obviously, advanced critical care, medicine, and nursing.

And her job here is to, like mine, is to check compliance. Hers is to check practice, and make sure that people are adhering to practice issues.

If we have a practice issue, we go to Kathy Hutchins. And she looks into it for us.

Q. Now, who was Ms. Hutchins going to report back to?

A. She reports to Mary Brown. And she would have reported back to Mary Brown.

Q. Okay. And at some point, did you learn that she had completed her investigation?

A. Yes. Kathy and Mary and I met. I can't give you the exact date. It would probably have been, if I had to guess -- I don't even like to guess dates, especially when I'm sworn under

oath. So, I'm not going to guess.

It was near the end of August. And we all sat -- the three of us sat down. And Kathy presented findings in a very, very specific, very detail-oriented method.

She had everybody written out, that we were able to follow very carefully.

It had taken her -- I bet it had taken her five or six days to get through it. But as she relayed to us, the handwriting was very, very hard to read.

She had to go through medical MARs, and she had to go through flow sheets, and she had to go through a lot of different documentation. So, she had to use the time for that.

Q. Now, at that point -- well, what was the next thing that happened?

A. Well, she brought her findings to Mary Brown. And then Mary Brown made a decision that we should meet with Nancy, to bring these issues to her, and see what she would have to say about it.

Q. Okay. And did you attend this meeting

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Page 58

signing those notes?
A. No. Just, as Kathy would update, I would be in the room with Kathy's updating. But it was only as a sheer, I guess you would say, FYI, or courteous --
Q. What do you mean, "as Kathy would update"? What was Kathy doing?
A. After this meeting, Kathy was then, which I think she's already testified, did an investigation. And she was reporting back to Mary on what she would find. And I would usually be in the room.
Q. Okay. And was another meeting scheduled?
A. Yes, there was.
Q. Okay. And is this the second meeting that's referred to in Exhibit 14, that you took notes of?
A. I took notes on that meeting. Correct.
Q. Okay. And so far as you know, is this an accurate representation of what happened at that meeting?
THE ARBITRATOR: This is August 29th?

Page 59

THE WITNESS: Yes. Yes. And I signed it. It's my signature. And Addie typed it for me.
Q. (By Mr. Cahillane) Now, in between the -- well, was it your understanding that in between the meetings, Ms. Hutchins had further looked into the records concerning these patients?
A. Correct.
Q. And what was the purpose in doing that, as you understood it?
A. Well, Nancy had given us feedback in her answers to our questions. So, what we did was Mary asked Kathy to then look further into those answers that she gave us, so that we could then respond.
Q. Okay. And did that include the situation with the bolus and the drip?
A. Yes.
Q. And was that discussed at the meeting?
A. Yes, it was.
Q. Okay. And what do you recall about that?
A. It turned out that after trying so --

Page 60

trying as hard as I did to understand it, it turned out the patient didn't even have an IV that day. The IV had been discontinued.
Q. And was that related to Nancy Default at the meeting?
A. That was relayed to her by Mary Brown.
Q. And what did Ms. Dufault say?
A. As well as I can remember, without my notes in front of me, she said, "That's how I remember it. I can't --" she kind of said, "I can't say anything else. That's how I remember it."
Q. And how did that meeting end?
A. Again, I would say there was four or five things brought to Nancy's attention.
There was two new cases presented at that time, that Kathy had found in the two days that were of concern.
We brought everything back to her, got her input again. And at the end of that, there was nothing really to tell us where the drug was. We had no idea where the drug was.
And there was no documentation in the med sheet. Mary made the decision to ask

Page 61

Nancy -- to terminate Nancy. I shouldn't say ask. Strike it. To terminate Nancy.
Q. And do you recall anything else that Nancy Default said at that meeting?
A. No. I don't. She just kept referring to the fact that she had charted -- it was a documentation issue. It was a charting issue. That she had given the drugs.
But at this meeting, there was also more evidence brought in that there was a lot of drug taken out that wasn't even ordered.
For instance, I remember: There was probably five or six morphine tubes that were taken out. The order was only for one milligram. And there was no documentation of where the waste on that was.
So, we brought to Nancy's attention that it's hospital policy, and it's policy across the nation, that when a nurse has wasted a narcotic, they have to have a second signature.
Not only did she not document it, but she also did not have a second signature.
So, it was a narcotic that was totally -- we couldn't account for it. So, we

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Q. -- those discrepancies?
A. Correct.
Q. You did not, following the investigation, or during the investigation, advise Mary Brown that the proper result in this case was to terminate Nancy Dufault?
A. No. Never.
Q. You didn't suggest that some other level of discipline was appropriate?
A. We didn't do levels of appropriateness.
Again, the information was brought to Mary. She made the decision. She did not ask my advice.
Q. And you didn't offer it without being asked?
A. I did not offer my advice.
Q. Do you have an understanding of why Nancy Dufault was terminated?
A. Of course I do. Yes.
Q. Okay. And what's the basis of your understanding?
A. My understanding would be --
Q. I'm not asking what your understanding

is. I'm asking how you came to an understanding.
A. I don't understand.
Q. Did somebody tell you, or is this based on your observation of the process?
A. Did someone tell me why she was being terminated? Is that what you're asking?
Q. Yes.
A. Yes. Mary Brown told me she was being terminated.
Q. And when did she tell you that?
A. She would have told me on the day after our last meeting with Nancy. That was exactly when she told me.
Q. So, August 30th?
A. I don't have anything in front of me.
Q. Sure. If I suggest to you that there were two meetings with Nancy, August 27th and 29th --
A. Right. After the second one.
THE ARBITRATOR: Don't step on his questions because --
THE WITNESS: I know. I'm sorry.
(Off-record discussion.)
Q. (By Mr. Hickernell) So, is it your

testimony then that Mary didn't tell you why Nancy had been terminated until after she had been terminated?
A. Mary did not tell me that Nancy was being terminated until after the second meeting. That was the question you asked me. And that's what I answered.
Mary did not tell me she was terminating Nancy until after the second meeting
Are you asking now if she told me why she was terminating her?
Q. My question is as to why. Yes.
A. At that point, did she tell me why?
Q. Yes.
A. Yes. She told me -- and again, we had the notes from the second meeting at that point, where there were significant discrepancies, time and time again, between drugs taken out of the machine, and Nancy not documenting the drugs being given to a patient.
So, as is policy at any hospital I've worked at, a nurse takes a drug out, and doesn't chart it, it's not been given. So, we did not know where the narcotics were.

So there, we made the -- Mary made the decision, based on policy, that Nancy would be terminated.
Q. And what specific policy are you referring to, when you say, "based on policy"?
A. What I just referred to in my head was nursing policy. I did not refer to Mercy policy at all. So, I should say standard nursing practice.
Q. When did you first learn that Nancy Dufault either would be or had been terminated?
A. After the second meeting.
Q. The day after the second meeting?
A. The day -- no. After the second meeting. So, after we left that meeting, Mary -- I went to Mary's office, and she told me.
Q. And were you present throughout the second meeting?
A. Yes, I was.
Q. And is it your testimony that Nancy was not informed that she was being terminated at the second meeting?
A. At the second meeting -- and again, I don't have my notes -- Mary said to Nancy, at the

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Page 74

very end, when Nancy had no answers to where all the drugs had gone, that Mary said to Nancy that, "There's a lot of discrepancies. We can't account for them. You have to answer for them. So, at this point, we're going to terminate you."

The Union rep was in the room, as was human resources. Mary then offered Nancy to talk to anybody in the room privately, if she wanted.

She chose not to. And we all left. And I believe she stayed behind with the Union rep.

Q. So, is it fair to say then that you learned that Nancy was being terminated during the second meeting?

A. It would have been at the very end, when she said it to Nancy. Correct.

Q. Right. I'm going to show you Joint Exhibit 2, please.

A. Mm-hmm. Mm-hmm.

Q. Have you seen that before?

A. Yes.

Q. And what is it?

A. It's a -- it's what we use to discipline, written warnings, up to and including

Page 75

termination.

Q. And do you have a memory as to whether Mary Brown gave that to Nancy at the second meeting?

A. No. I honestly do not.

Q. Do you remember the first time you saw that document?

A. No. I honestly do not. I would say it was very soon after. It was a long time ago. It was very soon after this whole -- this last meeting, which was the 29th of August.

So, it would have been soon thereafter the 29th of August that I would have signed this.

Q. And does your signature appear on there?

A. Mm-hmm.

Q. And is there a date next to your signature?

A. There's a date on -- not right next to my signature. No. Is that what you're asking?

Q. Did you write a date yourself at the same time you wrote a signature?

A. No, I did not.

Q. So, you don't have any way of telling,

Page 76

from that document, whether you signed it on the 29th, as well?

A. I can tell you I signed it before Bev Ventura did. And Bev Ventura signed it 8/29/02.

Q. Based on that recollection, do you conclude that you signed it on the 29th?

A. Based on that, I would say I signed it on the 29th.

Q. And did you review it --

A. Yes.

Q. -- prior to signing it?

A. It was only one sentence long. Correct.

Q. And the one sentence long on the second side of the page --

A. Mm-hmm.

Q. -- does that sentence summarize your understanding of the reasons that Nancy was terminated?

A. Correct.

Q. Okay.

THE ARBITRATOR: For convenience's sake, could I ask you to read that sentence into the record.

Page 77

THE WITNESS: Sure. "Failure to adhere to the standards of narcotic/controlled substance administration -- suspected drug diversion."

Q. (By Mr. Hickernell) And did your signature indicate that you agreed with the contents of the document?

A. My signature, as I understand it, on these things, is that I'm a -- that Nancy refused to sign, and that I am a witness that -- to two things.

I was a witness to the August 29th meeting, where she was given the information as to why she was being terminated; as well as being the manager of the ICU, and signing it.

Q. So, your signature doesn't indicate one way or another whether you agree with the contents of the document; is that what you're saying?

A. No. I would say it does agree with the contents. I'm sorry if I said that wrong.

Q. So, if you agreed that that was the reason for which she was being terminated, and that termination was appropriate for that, could

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Page 78

you explain to us what your understanding of suspected drug diversion was.
A. To me, suspected drug diversion, in any situation, is when we have narcotics taken out of -- right now, it's Omnicell -- and yet, they are not charted in the medical record as being given.
And by medical record, I mean our standard med sheet, which is our MAR here.
Q. And is it your testimony that suspected drug diversion does not mean that Nancy was suspected of having removed the drugs for her own use, or for the use of someone other than the patient?
MR. CAHILLANE: Objection.
THE ARBITRATOR: Sustained. It's a compound question. Ask it again.
* Q. (By Mr. Hickernell) All right. Do I understand, from your last answer, that suspected drug diversion does not mean, to you, that Nancy was suspected of having taken the drugs for her own use?
MR. CAHILLANE: Objection.
THE ARBITRATOR: Basis?

Page 79

MR. CAHILLANE: I just think he's mischaracterizing her prior testimony.
MR. HICKERNELL: Well, I'm asking her though.
THE ARBITRATOR: This is cross. You have a certain amount of latitude.
Did you understand the question?
THE WITNESS: Could you repeat it, please.
*(Question read.)
THE WITNESS: I don't get the question. Okay. Let me think. If you're asking me, right now, if I think that drug diversion means that Nancy was taking the drug --
Q. (By Mr. Hickernell) I'm asking what your understanding was, not right now, but at that time.
A. At that time, drug diversion means it was diverted away from the patient.
Nancy had the drug. The patient didn't get the drug. So, somehow, it was diverted away from the patient. That's how I understand it.
Q. Okay. And does your definition of

Page 80

drug diversion include an instance in which Nancy, or somebody else, had removed the drug from the Omnicell, and given it to the patient, as ordered, but failed to record it in the MAR?
A. I would have no way of knowing that.
Q. I didn't ask you if it happened. I asked you if that would be included in your definition of drug diversion.
A. I don't understand the question.
Q. Okay.
THE ARBITRATOR: Try again.
MR. HICKERNELL: I'll try again.
Q. (By Mr. Hickernell) You have testified so far, and please correct me if I mischaracterize you, that Nancy Dufault was fired for, among other things, suspected drug diversion.
A. Mm-hmm.
Q. And that you agreed that that's what she had been fired for?
A. Correct.
Q. And you agreed that that's what had happened; is that right?
A. Yes. Correct.

Page 81

Q. Okay. And you've told us that when the drugs disappear, basically, that that's diversion?
A. Correct.
Q. Now, I'm trying to -- well, you don't care what I'm trying to do. I'll just ask you questions.
THE ARBITRATOR: Her definition of suspected drug diversion is that it was diverted away from the patient.
MR. HICKERNELL: Right. But she's given a couple different answers.
Q. (By Mr. Hickernell) So, are you saying that drug diversion does not include instances in which the patient received the drug, but it was not recorded properly in the MAR?
A. I would have no way of knowing, if it wasn't recorded in the MAR, is what I'm saying. If you're saying if that were to occur.
THE ARBITRATOR: No, no, no. That's not the question.
THE WITNESS: I'm trying to answer it though.
THE ARBITRATOR: Listen to it

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Mary Brown took the lead in speaking for the Hospital?
A. Yes. Correct.
Q. And did you have a significant part in the discussion?
A. I would say I didn't say much.
Q. And I don't see, in the first or the second line, that Kathy Hutchins was present. Is that --
A. No, she wasn't.
Q. Okay. So, she didn't say anything?
A. Un-huh. Excuse me. No. She didn't.
Q. Okay. And based on your review of the second two pages of this document, and of your recollection of the meeting, is it fair to say that these two pages are not a verbatim transcript of the second meeting?
A. Only where I have quotes are they verbatim. If they're quoted, then that's exactly what they said, and I wrote it down as such.
Q. Okay. And if you didn't write anything down, then you don't know what was said?
MR. CAHILLANE: Objection.
THE WITNESS: Yeah. I guess I need

that clarified.
Q. (By Mr. Hickernell) Okay. Did you write everything down that was said at the meeting?
A. No.
Q. Okay. And in fact, had you written everything down, not only would your fingers likely have fallen off, but it would be a much longer document than a page and a half?
A. Right.
Q. Okay. And looking at this -- well, are you skilled in shorthand?
A. No.
Q. Okay. What did you do when you were taking notes during the second meeting to indicate that it was a direct quote?
A. I'm sorry. I didn't really understand the question.
Q. When you were taking the notes during the second meeting --
A. Mm-hmm.
Q. -- this reflects that -- actually, almost everything you wrote down has quotation marks on it.

A. Mm-hmm.
Q. Do you have a specific recollection -- well, strike that. Let me find a quote:
Actually, let me go back to the first two pages. I'm sorry.
A. Mm-hmm.
Q. Now, you testified that during the meeting, Mary gave Nancy the evidence that had been collected up to that point?
A. She went over each incidence with her.
Q. Okay. And with regard to the first numbered incident --
A. Mm-hmm.
Q. -- here, do you recall what documentation, or other evidence, Nancy was given?
A. No, I do not.
Q. And do you recall what documentation she was given for any of the instances?
A. You mean handed to her?
Q. Yes.
A. No. I don't remember. I don't remember -- I remember Mary going over the situations, and Nancy replying to the situations.

I don't remember her ever giving anything. And I don't remember Nancy ever asking for anything.
It was pretty much: "This is what happened." And then she would reply what had happened.
Q. Okay.
A. Nancy understood, when Mary said, "This instance." She understood. She didn't ask for any further explanation.
Q. And what makes it possible for you to state what Nancy's understanding was?
A. I would say clearly, because I was sitting in the room. And when Mary asked the question, Nancy would respond very strongly that that was the situation. "I did this," or, "I didn't do this," or "I need to get better at it," or, "I'm not good at it."
She never said, "I don't remember." She never said, "I can't recall." She never said, "I don't know what you're talking about." She never said, "Give me further --" so, from where I was sitting, it looked like she clearly understood what was going on. She responded

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Page 94

appropriately.
Q. So, as far as you could tell, at a meeting on August 27th, 2002, Nancy, without the benefit of any document, any review of charts --
A. Mm-hmm.
Q. -- remembered specifically the incident on June 19th?
MR. CAHILLANE: Objection.
THE ARBITRATOR: Overruled. This is cross.
THE WITNESS: I believe Nancy -- the way Mary presented it, Nancy was speaking to her practice, not necessarily the date of June 19th.
Mary presented June 19th as a situation. Nancy presented her answer as how she went about it.
MR. HICKERNELL: Okay.
THE WITNESS: I'm not saying she specifically remembered, on June 19th, she did this. No. Not at all.
MR. HICKERNELL: I think I'm almost done. Can we just go off the record for a moment.
(Recess taken.)

Page 95

THE ARBITRATOR: Okay. Back on.
MR. HICKERNELL: Just a few more questions.
THE WITNESS: Sure.
Q. (By Mr. Hickernell) Directing your attention to the August 27th meeting, the first meeting with the Grievant.
A. The first meeting. Correct.
Q. You said, if my notes are accurate, that at the end of that meeting, no one asked for anything; that is to say neither the union rep, nor Nancy asked for anything. Is that correct?
A. Correct.
Q. Had Mary Brown or anybody else from the Hospital told them, by the end of that meeting, that termination was contemplated?
A. Let me think. I remember Mary making it very clear that disciplinary action, up to and including termination -- I don't -- I don't -- I cannot say she said that. But I do believe that she said that disciplinary action would be considered.
Q. And do you remember her --
A. Exact words? You would have to ask

Page 96

her.
Q. I'd have to ask her if you remember them?
A. Oh, no, no, no. I thought you said what she said.
Q. Do you remember or not?
A. Do I remember what Mary said?
Q. Yes.
A. No. That's what I meant by you'd have to ask her. Ask her what she said.
Q. Okay. So, you don't remember?
A. I really -- I think I do, but I don't want to go on record.
Q. Well, if you think you do --
A. I want to be 100 percent sure. I'm under oath. So, I don't want to say something that's not completely accurate and correct. I mean, I want to be completely truthful. And I am being completely truthful.
So, for me to say something that I'm not absolutely, 100 percent sure of, I'm not going to say that.
I can tell you that I think, rather strongly, that Mary did.

Page 97

Q. But you don't recall, as you sit here today --
A. Correct.
Q. -- the exact words she used?
A. Correct. Correct.
Q. Okay. And directing your attention back to Hospital 14, the first page, Case 1.
A. Mm-hmm.
Q. That June incident, is that the same incident that you testified you had previously met with Nancy about?
A. Correct.
Q. That is the same incident?
A. Yes. I can tell, because within one minute's time, she had taken out quite a bit of Lorazepam.
MR. HICKERNELL: Okay. That's all the questions I have. Thank you.
THE ARBITRATOR: Anything on redirect?
MR. CAHILLANE: Yes. A few questions.

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REDIRECT EXAMINATION BY MR. CAHILLANE:

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Page 98

Q. Ms. D'Espinosa, when Mary Brown asked you to call Nancy Dufault and tell her she was being placed on administrative leave, what did Nancy Dufault say to you? Do you remember?
A. I called Nancy. She had worked the night before, because I remember thinking I was going to wake her up.
And I did. And I remember saying that we were going to put her on administrative leave because there was some issues with Omnicell and medication administration records.
I remember her saying specifically, "What?" And I remember saying that there were discrepancies that we were looking at, and that we would put her on administrative leave until we had the investigation completed.
Q. Okay. Anything else?
A. No. That was all I said on the phone.
Q. Well, my question was specifically what she said.
A. Oh. No.
Q. Okay. With respect to the two meetings that were held on August 27th and August 29th --

Page 99

A. Mm-hmm.
Q. -- there were different Union representatives present at those meetings?
A. Yes. One was Mona. And the second one was Dave Powers.
Q. And do you recall either of them saying anything during either meeting?
A. Yes. The second meeting, David Powers was the rep. And when we talked about the one that I had said earlier referred to as I didn't understand why she would ever do that, when Mary was presenting it, and said that she looked back at the patient, and Nancy was giving her explanation, Dave Powers looked at her and said, "Why would you do that?" out loud.
Q. Looked at who?
A. Looked at Nancy during the meeting, and said, "Why would you do that?"
Q. And that was with respect to which of these incidents?
A. It was with respect to Scenario Number 1 on August 29th, when Mary asked her about giving the 6 milligram boluses through an IV drip of Ativan that was already infusing.

Page 100

MR. CAHILLANE: That's all I have.
THE ARBITRATOR: This is regarding Scenario Number 1?
THE WITNESS: Correct. On August 29th.
THE ARBITRATOR: I'm sorry. Anything more?
MR. CAHILLANE: No. No other questions.
THE ARBITRATOR: Anything on recross?

RECROSS EXAMINATION BY MR. HICKERNELL:

Q. When you took the notes for the second meeting, were you attempting to make an accurate record of what happened at the meeting?
A. Yes.
Q. And you didn't include the remark that you just related by Dave Powers in your notes?
A. No. I didn't think it was relevant.
Q. Okay. And was there something that spurred your recollection of that particular comment?
A. At the time, I thought it was odd that

Page 101

her union rep would say to her, "Why would you do that?" So, I remembered that, as bad as my memory is. That shocked me.
And I was very shocked that her Union rep would look at her, and ask her why she would do something like that.
So, it stayed with me, yes. It stayed with me a very long time.
Q. And since it stayed with you, can you show us where, in the discussion of this Scenario Number 1, Mr. Powers said that?
A. It was Scenario Number 1. Mary was going over, if you look at Scenario Number 1, paragraph number 1, Mary goes over the situation with Nancy.
Nancy says, "Yes. I remember that situation."
Mary goes on to say, "You went on to tell us this was possible because what you had done," I've already said it, "was giving 6 milligrams boluses through the IV drip of Ativan."
It was in that time frame of that paragraph that Dave looked at Nancy, and said,

Page 126

it.

And she also showed me a couple of examples where, again, she documented giving narcotics prior to taking them out of the Omnicell.

Q. Now, prior to this meeting, the second meeting, had you considered what action you would or would not take with respect to Nancy Dufault?

A. Yes. I had weighed the seriousness of what -- and the discrepancies of the first meeting, and had a lot of concern about that. And I did speak to my vice president.

Q. And who is that?

A. That's Beverly Ventura.

Q. And what happened when you talked to her?

A. She also -- you know, I reviewed the meeting, the information, Nancy's responses. And at that point, we were very suspicious that we had some type of drug diversion going on.

Q. Okay. Was any decision made as to what you would do at the August 29th meeting?

A. In my conversation with Beverly, we discussed a couple of options.

Page 127

One was that if, in fact, Nancy was in trouble of some type -- and I'm talking about substance abuse -- that we would recommend that she go on a leave of absence, pending completion of what they call here the SARP, the Substance Abuse Rehabilitation Program through the Board of Registration of Nursing.

THE ARBITRATOR: SARP?

THE WITNESS: SARP is the Substance Abuse Rehabilitation Program. That was one option that Beverly and I had discussed and agreed to.

The other option was that if we could not resolve the discrepancies at the second meeting that was scheduled for the 29th, that we would have no option but to terminate Nancy, based on suspected drug diversion, and report her.

Q. (By Mr. Cahillane) Okay. Now, going into Hospital Exhibit Number 14, was she, again, questioned concerning the incident on the patient PR at that meeting?

MR. HICKERNELL: Which meeting? I'm sorry.

Page 128

MR. CAHILLANE: Scenario Number 1.

THE WITNESS: The patient PR.

MR. HICKERNELL: The second meeting?

MR. CAHILLANE: The second meeting, on the 29th.

THE WITNESS: Yes. I told Nancy I was very concerned about the explanation that she had given me; and that after further investigation, the IV had, in fact, been discontinued the day before.

So that the explanation she had given me on the 27th could not be possible, that she had bolused through the IV.

Q. (By Mr. Cahillane) And what was her response to that?

A. She said that -- she had no answer. That's what she recalled.

Q. And then, was there another matter that you brought up here, referred to as Scenario Number 2?

A. Yes. This is a case where, again, there had been Ativan -- I'm sorry; this was morphine -- morphine removed at 6:20 in the morning. And she had documented that she gave it

Page 129

at 2:00 a.m.

In that particular report, there was no other -- that I had presented to her, there was no other morphine removed on that patient.

Q. Okay.

A. And I presented her three other similar scenarios, where she documented giving morphine prior to removing it from the Omnicell.

Q. And did she have a response to that?

A. That those are the times that she charted, and it must have been wrong in her charting.

MR. HICKERNELL: And if the record could continue to reflect that the witness is referring to Hospital Exhibit 14.

Q. (By Mr. Cahillane) And was there still another scenario that you also presented her with at that time?

A. Yes. On that particular patient, on May 14th, she took out morphine three times on the patient.

At 11:41 p.m., she took out 2 milligrams. It was not charted. At 1:39 a.m., she took out 4 milligrams. It was not charted.

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Page 130

And seven minutes later, at 1:46 a.m., she took out 10 milligrams. And it was not charted.

And I asked how she could take out, in seven minutes, 14 milligrams of morphine on the same patient. She did not have an explanation.

And certainly, that was over the amount that the doctor had ordered on that patient.

THE ARBITRATOR: Let me interrupt for one second. Do we have a patient initials for Scenario 3?

MR. CAHILLANE: Yes. Actually, it is the patient on the other exhibits whose initials are CI.

THE ARBITRATOR: Okay.

MR. CAHILLANE: And I see that we just missed on the redacting of the last name up there.

THE ARBITRATOR: Okay. I wasn't sure if that's the case.

MR. CAHILLANE: I think that's Patient Number 5 on the prior exhibits.

Q. (By Mr. Cahillane) So, at that time, Ms. Brown, did you make a decision as to what to

Page 131

do?

A. Yes. Since there was no plausible explanation that I could see for any of this; there was so many cases where medication was taken out, documented it had been given previously; the comments about bolusing through the IV could not be accurate because the IV had been discontinued; there were too many discrepancies at that point, without any explanation.

So, the decision was made to terminate Nancy for failing to adhere to our administration policy, and suspected drug diversion.

Q. At either of these meetings, was there any other explanation given by Nancy Dufault or the union representative concerning these matters that was not recorded in these notes?

A. No.

Q. Or that you have not testified to?

A. No.

Q. Did either Ms. Dufault or the union representative ask for anything else at either meeting?

A. No.

Page 132

Q. And I take it that you then procured a disciplinary action form, which is, I believe, Joint Exhibit Number 2?

A. That's correct.

Q. Okay. You might want to look at the other side.

A. Mm-hmm. That's correct.

Q. One other thing, Ms. Brown: Does the hospital have policies regarding medication practice, in terms of giving it to patients?

A. Yes, it does.

Q. I'm just going to show you a copy of a document, and ask you if that is the nursing department policy with respect to medications?

A. Yes, it is.

MR. CAHILLANE: And I would like to introduce that.

THE ARBITRATOR: Let's identify it as Hospital 15.

MR. HICKERNELL: Can I have a moment to review it, please.

Can I have voir dire on this, please?

THE ARBITRATOR: Yes. Is Hospital 15 being offered into evidence at this time?

Page 133

MR. CAHILLANE: Oh, I'm sorry. I thought I had. Yes. I am offering it as evidence.

THE ARBITRATOR: Okay. Voir dire questions.

VOIR DIRE BY MR. HICKERNELL:

Q. Okay. Ms. Brown, is this the policy that was in effect in 2002?

A. Yes.

Q. And has it been revised since?

A. No.

Q. So, it's still in effect?

A. This is still in effect.

Q. There's some references in the document to appendixes and attachments?

A. There's an Appendix C. It looks like it's a chemotherapy order form. I didn't attach that in. It's a written standard order form for chemotherapy.

Q. On the second page, the last bullet point, there's a reference to Attachments 1 and 2. What are those?

I

Page 150

are not a verbatim transcript of the first meeting?
A. No. There was no verbatim transcript of the meeting.
Q. And in fact, a verbatim transcript would be substantially longer than the two pages here?
A. Mm-hmm.
Q. Did you consider, at any time, asking Nancy Dufault to undergo a drug test?
A. No. We didn't ask her -- we didn't ask her.
Q. And did you consider asking her?
A. No. That was not part of the initial consideration. And it did not come up in further conversations, because of the responses that we received in those meetings, which was pretty much stating that she either couldn't recall, or she had bad documentation.
It did not seem to be something that was appropriate to ask at that time, since she was claiming all of this was just poor documentation.
Q. So, fair to say that with regard to

Page 151

the issue of substance abuse and SARP, you were asking for Nancy to state that she needed help?
A. We were asking for an explanation for the scenarios that we presented to her around numerous discrepancies between the medication she removed from the machine, and what she documented.
And I was not asking her to step forward to tell me, you know, if she was using the drugs. I simply was asking, in the meetings, for an explanation of the discrepancies.
Q. Right. But you told me a few minutes ago about your meeting with Ms. Ventura.
A. Mm-hmm.
Q. And as I understood it, you discussed the possibility of SARP. And there was an agreement that if she asked for help, you would at least consider putting her on a leave of absence while she underwent the SARP program. Is that correct?
A. Correct.
Q. So then, is it fair to say that with regard to the issue of substance abuse, you were waiting for her to ask for help?

Page 152

A. I did give her, I thought, an opportunity. At the end of the -- which I forgot to tell you. You asked that.
At the end of the August 29th meeting, which the HR person was there, myself, Jean, her Union rep, and Nancy, before we concluded the meeting, I did ask her if she would like to have a private conversation with anyone that was present in the room, including HR.
And I was trying to give her an opportunity, that if she had an issue, and wanted to bring that forward, that any one of us would have been available to sit with her.
But at that point, she only remained in the room with Dave Powers, who was the MNA rep.
Q. Did you ever observe in Nancy, or have anyone report to you, an observation of an erratic behavior consistent with drug abuse?
A. No.
Q. Can I direct your attention to Joint Exhibit 1, please.
THE ARBITRATOR: Joint Exhibit 1 is the collective bargaining agreement?

Page 153

MR. HICKERNELL: Yes.
Q. (By Mr. Hickernell) And specifically referring to Section 6.09 on page 17.
A. Mm-hmm.
Q. And in your current position, are you generally aware of the terms of the collective bargaining agreement?
A. Yes, I am.
Q. All right. And are you specifically aware of the existence of Section 6.09?
A. Yes, I am.
Q. And was that section in existence in 2002?
A. Yes.
Q. And did you consider invoking that section in dealing with Ms. Dufault?
A. There was not a question of fitness for duty at that time. We were questioning drug diversion.
She did not have anything that made me think, clinically, that she was involved in -- that it was a fitness for duty issue.
Q. Okay. During the August 27th meeting, when you were presenting the cases to Nancy, the

Vol. II

Page 70

A. I did come up with one that had multiple -- I had removed multiple vials of Ativan, and thinking, at the time, that it might send a trigger off to pharmacy.

But as I wanted accountability for my med, that I had signed off.

Q. And what did you do next?

A. The weekend went by. And I got a call from Mary Brown on Monday morning at 8:30 in the morning, setting up the meeting for 8/27 at 10:00 o'clock.

Q. And as best you recall, what did she say when she called you?

A. This was my chance to dispute the discrepancy, or give my explanation of the transgressions that they had found between the Omnicell and my SMS documentation.

Q. And what did you say, if anything?

A. I don't think I said anything special. Nothing that I can recall.

Q. What happened next?

A. I went to the meeting the next morning. Mona, the union rep, Jane D'Espinosa was there, Mary Brown, and myself.

Page 71

Q. And as best you can recall, will you tell us what happened at the meeting, identifying specific speakers when possible.

A. Mary Brown sat to my left. On my right, immediate right, was Mona, the Union rep. And Jean was on her right.

At the meeting, Mary presented me with Omnicell readouts, which was the first time I had ever seen any of those sheets, and our MARs or SRS readouts of documentation of the medications that were administered to the patients.

THE ARBITRATOR: Had you seen MAR readouts before?

THE WITNESS: Yes, I had. Those are our work sheets that we use on the unit.

THE ARBITRATOR: But the readouts you had seen before?

THE WITNESS: Right.

THE ARBITRATOR: But not the Omnicell readout?

THE WITNESS: Right.

Q. (By Mr. Hickernell) And what happened? Can you describe more specifically what happened as she made that presentation to you?

Page 72

A. The meeting lasted between 30 to 40 minutes. She would present -- show me the Omnicell, show me the SMS, and then expect me to recollect what had transpired on this or caused me this discrepancy.

Q. And did the cases that she showed you correspond to the cases set forth by the Hospital in its presentation here?

A. Yes, they did.

Q. And other than the Omnicell and the SMS printout, what documents were you shown?

A. None.

Q. Was there no case in which you were shown any other documents?

A. No, there was not. Not at the first meeting.

Q. And were you able, on the 27th, to recall the specific instances that were presented to you?

A. I tried to give responses to what could have happened, or what could have caused this discrepancy on them.

But not knowing who the patients were,

Page 73

or even being able to associate, even if they gave me a name, what the patient was -- I mean, most of the events were two months prior.

Q. So, were you able to recall the specific instances?

A. Example: The Ativan that they questioned me about, the 320 milligrams, I said I must have mixed -- I had removed from the Omnicell 320 milligrams at 6:34, thereabouts, according to the Omnicell readout.

I said, "I must have mixed two drips at 160 concentration, that I would have failed to sign one drip out, depending on when the time was calculated, what the drip was," which Jean informed me was 25 ccs an hour.

So that, it would be, for my 12-hour shift, I would need 300 milligrams. And I had taken 320 out.

Q. And as you made those statements at the meeting, did you have a specific recollection of what had happened?

A. Not really. Not even of the Ativan. I would just surmise that that is what I did with the -- took out the 320, and mixed two drips, one

Page 74

being for when I would need it, whatever time on my shift.

Because hopefully, this drip which was already infusing, going at 25 an hour, whatever time the previous nurse to me would have hung it, depending on when I would have signed it out, or would need it in the SRS, and then leave a courtesy, or enough medication, so they don't immediately, upon assumption of the patient care, have to mix a bag.

Q. And was anybody taking notes at that meeting?

A. Jean D'Espinosa.

Q. Anybody else?

A. Not that I can recall. Oh, and Mona was, the Union --

Q. I'm going to show you what's been marked as Hospital Exhibit Number 14. And specifically, the first two pages.

Drawing your attention to Case 1, there's a quotation attributed to you there. Did you say that?

THE ARBITRATOR: Read it into the record, just so it's clearer.

Page 75

Q. (By Mr. Hickernell) The quotation attributed to Nancy says, "I gave the drug -- just didn't chart it," unquote.

A. I cannot recall if I said those words specifically. I know that I asked Jean if it was not documented in the nurse's flow sheet that the drip was going at 25 an hour.

And her response to me was that, "If it's not charted, it's not documented," that, "The nurse's notes is not a legal part of the chart."

Q. Drawing your attention to Case Number 2, there's a quotation attributed to you. Quote, "Equal to the dose ordered," unquote. Did you make that statement?

A. I could have.

Q. And in the second part of Case 2, there's a quote attributed to you. Quote, "Have no answer for that," unquote. Did you make that statement?

A. They expected me to recall patients, that in administering this medication to this patient, I could not lie and say that I remembered medicating Shelly's patient for her.

Page 76

So, I may have said, "I have no answer for this."

Q. On the second page, in Case 3, there's a quotation attributed to you. "I guess I didn't chart it .... Bad documentation on my part," unquote. Did you say that?

A. On this instance, I asked Jean if there was nothing charted around the nurse's notes around the time x-ray comes through. She said there was not.

It is not my practice with an orientee to document, unless something is transgressing, or I need to intervene.

So, I can't imagine that I said, "Bad documentation on my part," because I would have expected Tawnia to be doing the documentation.

Q. And you referred to your practice. What was your practice with regard to documenting while you were precepting another nurse?

A. Unless I had to intervene to do something, say a doctor was giving the nurse a hard time, or the patient was overcomplicating the orientee, as a preceptor, I did not step in. I allowed them to be able to manage their time and their skills.

Page 77

Q. Drawing your attention to Case Number 4, there's a quotation attributed to you. "I bolused through the IV drip ... Used 999 to bolus at 8:12 and 4:30 ... Then used the 18 milligrams to replace the IV," unquote. Did you say that?

A. What I said was something similar to that. This was the only account, in the time that they had placed me on administrative leave, of my being able to recall anything that might be alarming to the pharmacy, which is what Jean said had -- something had triggered the pharmacy's readouts.

And I said that I did recall this instance and what I had done with the medication. Mary Brown is the one who told me how much medication I had removed from the Omnicell.

I did say that I bolused through the drip, hanging drip. I do not recall saying that the drip was running.

However, I did not go any further, when I thought about what I had done, because of my practice issues regarding adding medication to an existing IV drip.

Vol. III

Page 86

came from specific medical records, correct?
A. The Omnicell readouts and the SMS that she showed me. Yes.
Q. And during and after that meeting, you did not ask for copies of those records or of any further records from those patients, did you?
A. No, I did not.
Q. All right. And at the first meeting, you had a union representative there with you?
A. Yes, I did.
Q. Did the union representative ask for copies of those medical records?
A. I do not believe she did.
Q. And at the second meeting, you again had a union representative there, present with you, did you not?
A. I did.
Q. And neither you nor the Union representative, at or after the second meeting, asked for copies of the medical records that were being shown to you?
A. We did not.
Q. And that's because you already knew that what was going on here was that you had

Page 87

overmedicated the patients?
A. I've never heard of a nurse being fired because they made a med error, in my 25 years at Mercy.
Q. Well, what if the overmedication was because the nurse didn't agree with the doctor's order, and thought the patient was agitated or disturbed and needed more? Would that be grounds for termination, do you believe?
MR. HICKERNELL: Objection. Foundation. How is she in a position to administer discipline?
MR. CAHILLANE: I'm asking her opinion of whether or not it would be grounds for termination if a nurse decided to administer more medication to the patient than had been ordered by the doctor.
THE ARBITRATOR: Is the Hospital now saying that this Grievant was terminated for suspected overmedication?
MR. CAHILLANE: No. What happened, I thought that the Grievant freely admitted in her direct testimony, was that the explanation for the missing narcotics is that she gave too much

Page 88

to the patient.
THE ARBITRATOR: Listen to the questions carefully.
Q. (By Mr. Cahillane) Well, would you agree that if a nurse decided to give more medication, particularly a narcotic, to a patient than was prescribed by the doctor, that that could be grounds for termination?
A. Again, I have never heard of this. And I can't imagine a nurse doing that.
Q. Now, if we could just go to the case of the patient PR, which is on Hospital Exhibit Number 5.
MR. CAHILLANE: And am I correct, Mark, Union Exhibit 5?
MR. HICKERNELL: I'll have to check. I think PR may be in Union Exhibits 5 and 6. Would you like the witness to be given both of those?
MR. CAHILLANE: Well, she might want them in front of her.
Q. (By Mr. Cahillane) On August 27th, you were presented with some information by Mary Brown concerning this patient and what had

Page 89

occurred between June 19th and June 21st, correct?
A. Information being the Omnicell readout and the SMS readout.
Q. And did you not testify that you yourself, at the time, in August, questioned your own practice with respect to the time when you state that you bolused the medication into the patient?
A. I questioned my practice of administering or adding to the bag medication, yes.
Q. And you said, in fact, that it was not a common practice?
A. Absolutely.
Q. And in fact, it's not a proper practice, is it?
A. No. As I had never done it before, I would say no.
THE ARBITRATOR: Do we have a definition of bolusing in the Hospital records, so that we all know what bolusing is? What's the definition?
Q. (By Mr. Cahillane) As you understand

III

Page 154

of the termination, correct?
A. Correct.
Q. And that used the term suspicion of diversion of controlled substances, correct?
A. Question of.
Q. Question of. And at that point, or shortly thereafter, you and/or the Union, on your behalf, filed a grievance concerning your termination, correct?
A. I believe that's proper practice.
Q. Well, that's what happened, correct?
MR. HICKERNELL: Just answer the question.
Q. (By Mr. Cahillane) You filed a grievance?
A. I told David to file a grievance. Yes.
Q. And in the grievance procedure, when you were terminated, you first had a chance to have your grievance heard internally, at the Hospital, by, I believe it's the Hospital president, or his designee, correct?
A. Because this was a termination, I understand it goes straight to Step 3? Is that

Page 155

what you're asking?
Q. Yes.
A. Correct.
Q. Okay. But at that point, you have the opportunity, do you not, together with the Union, to present your case for why you should not have been fired?
THE ARBITRATOR: At the Step 3 hearing?
MR. CAHILLANE: Yes.
THE WITNESS: I would not know what the protocol is. But if you're telling me that's it, yes. If that's the Union, yes. Correct.
Q. (By Mr. Cahillane) Well, let me ask you this: Did you understand that the grievance proceedings provided you with an opportunity to make your claim that the Hospital had violated the contract by terminating you?
A. Correct.
Q. Did you go to the Step 3 hearing?
A. Yes, I did.
Q. And when you went to the Step 3 hearing, did you indicate, in any way, that, "This is just a matter of my having made a

Page 156

medication error"?
A. No, we did not.
THE ARBITRATOR: Now, medication error? Is that what you meant?
MR. CAHILLANE: Yes.
THE ARBITRATOR: As opposed to documentation error?
MR. CAHILLANE: Yes.
THE ARBITRATOR: Okay. Keep me on board. Those are two different things.
Q. (By Mr. Cahillane) Well, you understood, at this point, by the time of the Step 3 grievance, you understood that you had not been fired just for a documentation error?
A. That they were accusing me of diversion of controlled substance, either using, or in some way inaccountability for medication that I had withdrawn from the Omnicell. Correct.
Q. Okay. So, you understood that. But you didn't indicate, at the Step 3 hearing, that, "There's no just cause for my termination, because this, in fact, was just a medication error on my part," or errors?
THE ARBITRATOR: Wait, wait, wait.

Page 157

Now are you misspeaking yourself.
MR. CAHILLANE: No. That's exactly what I mean.
THE ARBITRATOR: Okay. Medication error. The question is -- state the question again.
Q. (By Mr. Cahillane) Well, do I understand that here, in these proceedings, Miss Dufault, it's your contention that whatever discrepancies exist in the record as to the amount of drugs withdrawn, versus the amount of drugs given the patient are explainable by inadvertent medication errors on your part?
THE ARBITRATOR: What is a medication error, by your definition?
MR. CAHILLANE: Giving a patient too much or too little of the drug that was prescribed to them. Or not giving it at all. Or giving a medication that had not been prescribed.
THE ARBITRATOR: That's a lot of different kinds of medication errors.
Q. (By Mr. Cahillane) Well, in this case, let me amend my question to be: Is it your contention, here and now, that whatever

III

Page 162

is the responsibility of the nurse to document all meds/IVs given prior to leaving the hospital, and when the next shift's MAS are printed. RNs on the night shift will check all physician's orders written," I take it it is during, "the past 24 hours, and the medication administration schedule to assure accuracy."

Q. (By Mr. Cahillane) Do you see that paragraph, Miss Dufault?

A. Yes, I do.

Q. Now, the MAS is, is it not, a medical administration sheet?

THE ARBITRATOR: Is that synonymous with the SMS.

MR. CAHILLANE: I'm going to ask that question next.

THE WITNESS: That's the med sheet that we get, the MAS.

Q. (By Mr. Cahillane) Right. And is the MAS, the med sheet, is it like this document here?

A. Yes, it is.

Q. One of the --

A. Well, what we've been calling the SMS,

Page 163

which is the equivalent with the MAR?

Q. Yes.

MR. HICKERNELL: Can you tell us what document you just showed her, for the record.

MR. CAHILLANE: Well, this one happens to be -- I didn't write that exhibit on it. But it regards patient B. I believe this one is -- well, it's the July 17th incident. This must be patient BB. It's page 2.

But what I'm showing is a medical administration sheet, that I believe there is one contained in the records that we have in both exhibits for every single patient.

THE ARBITRATOR: Except that there, it's called the MAR, instead of the MAS.

MR. CAHILLANE: Correct. I just want to ask her about that.

THE ARBITRATOR: Okay.

Q. (By Mr. Cahillane) Those medical administration sheets, Miss Dufault, are the computer's record of the medicine that's been administered to that patient, correct?

A. Correct.

Q. And they are part of the MAR, or the

Page 164

SMS computer record, correct?

A. The SMSs that you show us, we have a work sheet that we work off, that that gets discarded.

Q. Well, this document, which is labeled the, "Medical Administration Record," this is what the policy here is referring to, the same thing as what the policy here is referring to as MAS, correct?

MR. HICKERNELL: And can the record just reflect that Mr. Cahillane is holding up Union Exhibit 21, page 2.

Q. (By Mr. Cahillane) Let me ask you this, Miss Dufault: Is it not the case that each day, there is a medical administration sheet printed off the computer?

A. That goes into the permanent record?

Q. Well, is one printed off?

A. One that we write on and discard, that the secretaries run off at the beginning of the shift.

Q. And that is printed off of the computerized record, correct?

A. Correct.

Page 165

Q. Okay. So, the information concerning medication administration that is inputted by you or other nurses into the computer is printed out on a daily basis?

A. Correct.

Q. And it's there for the nurses' and the doctors' use?

A. If they needed it. I don't ever recall a nurse going back into the permanent record to see. But I guess, yes. Correct.

Q. That's the permanent record. I'm talking now about the medical administration sheet that's printed each day.

A. You throw that out at the end of each shift.

Q. Okay. But it's printed up for a reason, isn't it?

A. For you to work off for whatever shift you're there. And then it's discarded.

Q. Okay. So, every day, with respect to the patient, you're printing, out of the computerized record, the record that the computer has of the medicine that's been administered to that patient, correct?

Vol. IV

as far -- what did that consist of at Mercy Hospital?
A. Going way back, it was usually a --
Q. Well, let me just say, the last year that you were in active practice.
A. At Mercy --
MS. BUTLER: Are we going back now to 2000? Just to keep me oriented in time.
MR. CAHILLANE: Well, why don't I -- I don't want to go through 30 years.
A. I could summarize if you'd like.
Q. (By Mr. Cahillane) Are you familiar with what would have been -- what was being done at the hospital with respect to documentation of controlled substances in 2002?
A. I believe so, sir, yes.
Q. Okay. And what record would the physician have had to look at with respect to the administration of a controlled substance in 2002?
A. Basically, there were two sources that I would usually turn to.
And if I can modify, briefly, my previous testimony: My active practice terminated July 2001. I hoped to return -- and

actually provided care for a couple weeks in August of 2001, after the first of two back operations that year. The second occurred on 9/11/2001, that famous day. And I did subsequently operate in 2002 on two physicians' wives, in the process of hoping to return to active practice. And I think it was in the process of doing those procedures that it became obviously apparent that I was not going to be able to sustain the levels of practice to have an active surgical practice that would produce enough to cover the expenses and the income.
To continue back to the question that you addressed, there were two sources that I would generally turn to. The SMS system is a computer system for recording administered medications. And I believe the record is called the MAR, or the medicine administration record. That was a printed out every 24 hours and would be put in the patient's record. So that if I wanted to know what the patient received prior -- or somewhere up to the time of that being printed out, I would go to that. And that would give me a summation of what the patient received and

when. Be it antibiotic, pain medication, blood pressure supportive medication, every medication would be there.
If I needed something within the preceding several hours, I would then, basically, access the MAR, where this was on computer and had not yet been printed out. Many times, I would either go to -- I would -- I would many times talk with the nurse or go to that record.
But that record was what I expected to tell me, as the responsible physician, what happened from the day that patient came in to the moment that I looked at her.
Q. And would --
MS. BUTLER: And there was a second record, you said.
THE WITNESS: I'm sorry?
MS. BUTLER: You said the doctor looks at two sources.
THE WITNESS: Well, it's the same record, but because it's printed out every 24 hours, in the chart there is an actual printout. On the computer system -- from the time that was printed out until the

time the next printout occurs is on the actual computer SMS system.
MS. BUTLER: Okay. So the second source would be, if you didn't find out or you weren't fully satisfied, you would go to the computer itself.
THE WITNESS: Yes.
MS. BUTLER: That was what you meant by second source.
THE WITNESS: Yes.
MS. BUTLER: Okay.
THE WITNESS: And that would cover from the time the patient was admitted to the very moment that I was looking at the patient.
Q. (By Mr. Cahillane) And would a -- would it be fair to say that a physician might well be relying on that record, or records, in making decisions as to patient care?
A. Absolutely.
Q. And would that be important with respect to the administration of controlled substances?
A. Yes, it is.

IV

(Robert J. Kasper, M.D., stepped down from the witness stand.)

MR. CAHILLANE: I should get my next witness.

MS. BUTLER: Yes, please.

MR. HICKERNELL: In the meantime, can we enter this as a union exhibit?

MS. BUTLER: Okay. What would it be? Where are we up to now? I see a Union 21. That may be the last one.

MR. HICKERNELL: I think that's the last one.

(Union Exhibit 22, Pharmacy Department Medication Events and Adverse Drug Reactions Policy, admitted)

MS. BUTLER: Let the record show Union Exhibit 22 is admitted without objection.

(Pause in proceedings)

(Patricia Duclos-Miller, R.N., approached the witness stand.)

MS. BUTLER: Please stand and rise your right hand.

Do you swear, or affirm, the testimony you're about to give in this arbitration hearing will be the truth, the whole truth, and nothing but the truth, so help you God?

MS. DUCLOS-MILLER: I do.

MS. BUTLER: Thanks.

PATRICIA DUCLOS-MILLER, R.N., Witness, having been duly sworn, testifies and states as follows:

DIRECT EXAMINATION BY MR. CAHILLANE:

Q. Could you state your name, please?
A. Patricia Duclos-Miller.
Q. And what is your address?
A. 15 Maplewood Road in Farmington, Connecticut.
Q. And what is your present employment

position?
A. Director of quality improvement for the Sisters of Providence Health System.
Q. And could you just -- if you could, briefly describe your education and what degrees you hold.
A. Graduate of St. Anselm College, with a baccalaureate degree in nursing. Boston University with a master's. And I'm certified in nursing administration by the Academy.
Q. And have you been a practicing registered nurse?
A. For over 30 years.
Q. Okay. And what positions have you held?
A. I've been director of organizational systems, director of specialty services, nurse manager, staff nurse, former assistant professor at various collegiate programs in the state of Connecticut, and director of nursing.
Q. And when were you first employed by the Sisters of Providence Health System?
A. December 2001.
Q. And just so I'm sure that it's ever

been on the record, but Mercy Hospital is part of the Sisters --
A. Correct.
Q. -- of Providence Health System?
And what are your job duties at Mercy Hospital, or Sisters of Providence Health System?
A. To provide resources, in collaboration with quality improvement projects, data management. I've lectured, worked with and facilitated root cause analysis, intensive investigations. I work with physicians on peer review committees and facilitate all of the quality improvement councils.
Q. And have your duties included holding in-service projects regarding proper practice?
A. Yes.
Q. Including proper practice for registered nurses and LPNs?
A. Yes.
Q. And are you, from your position here, familiar with the standards at Mercy Hospital with respect to the administration of

IV

Page 34

and documentation of controlled substances?
A. Yes.
Q. With respect to the administration of medication by a registered nurse, are you familiar with something called the Five Rights?
A. Yes.
Q. And what are they?
A. Right patient, right dose, right medication, right route, right time.
Q. And is this a standard which all nurses -- all registered nurses have to follow?
A. All nurses. All licensed nurses, including licensed practical nurses.
Q. Now, and I take it that those standards apply for any narcotic or other dangerous drug?
A. That's correct. It's a fundamentals of nursing, in one of your first nursing courses.
Q. Now, with respect to the administration of a controlled substance by a registered nurse at Mercy Hospital, are you familiar with where the registered nurse who administers a controlled substance is supposed to document that?

Page 35

A. Yes.
Q. And where is that?
A. In the computer, in what's called the MAR module of the computer.
Q. And is that also referred to as the SMS?
A. Well, that's the -- the SMS is the computer vendor that we currently utilize. The MAR is a module within that computer.
MS. BUTLER: But they're sometimes used synonymously.
THE WITNESS: Yes.
Q. (By Mr. Cahillane) And is that system at Mercy Hospital, is it relied upon by physicians and nurses, in order to determine what medications a patient has or has not received?
A. That's correct.
Q. Would it be inappropriate practice -- well, is there also on the floor a written medical record that nurses sometimes make?
A. Documentation in the progress notes?
Q. Yes.
A. Sometimes a nurse will document in

Page 36

the progress notes.
Q. Would it be an appropriate practice for a nurse administering a controlled substance to document it in the nursing notes, but not in the MAR?
A. No, that is not the correct method.
Q. Would it be appropriate for a nurse, in documenting the administration of a controlled substance, to not put the amount of the dosage given to the patient?
A. That is an improper method of documentation.
Q. Would it be a proper -- proper for the nurse to not put the correct time at which the controlled substance was administered?
A. That is an improper way to document.
Q. Would it be acceptable for the nurse to sometimes document the administration of a controlled substance in the nursing notes, but not in the MAR?
A. No, that is unacceptable. It is not the policy or the standard.
Q. Would it be an acceptable practice for a nurse to -- in administering a controlled

Page 37

substance, to take out additional medication ahead of time, in anticipation that there might be in the future an increase in the dosage for the patient?
A. No. That is improper.
Q. If a patient were receiving a controlled substance by means of a drip, an IV drip, and the physician ordered the drip discontinued, would it be appropriate for the nurse to later -- who later has an order for an IV push for a dose of that drug, to use the discontinued drip?
A. No. That is an incorrect and improper method.
Q. And would it be fair to say that a registered nurse would be obligated to follow the physician's order with respect to that drip?
A. That is correct. The physician's order said "IV push."
Q. Would it be appropriate for a nurse to have a different standard of documentation with respect to the administration of a controlled substance for a patient who was a DNR?
A. No. There should be no difference

IV

in standard.
Q. Are you familiar with there being such a practice or standard at Mercy Hospital?
A. No.
MR. CAHILLANE: That's all.
MS. BUTLER: You have to answer for the record. Your answer was?
THE WITNESS: No.
MS. BUTLER: Okay.
Your witness, Mr. Hickernell.
MR. HICKERNELL: Just have a two-minute break?
MS. BUTLER: Two-minute break.
(Pause in proceedings)
MR. CAHILLANE: I do have one other question that I forgot to ask, if I may.
MS. BUTLER: Okay. Back on the record. An afterthought type question.
Q. (By Mr. Cahillane) Ms. Duclos, if a registered nurse has, for whatever reason, withdrawn more narcotic than what is prescribed and in fact only gives what is prescribed, what is the standard of practice as to what she does with the additional narcotic?

A. The additional narcotic --
Q. Or controlled substance.
A. -- controlled substance needs to be wasted, and that needs to be countersigned by another registered nurse.
MR. CAHILLANE: That's all.
MR. HICKERNELL: All set for cross?
MS. BUTLER: Okay. Yes, go ahead.

CROSS-EXAMINATION BY MR. HICKERNELL:

Q. Good morning.
Where is your current place of work?
A. Here. My office is here, but I work for the Sisters of Providence Health System, of which Mercy Medical Center is part of that system.
Q. And, as a director of quality improvement for the system, are you responsible for other hospitals as well?
A. Providence, which is considered part of Mercy Medical Center. I'm a resource to the long-term care facilities, which are part of the health system, and the home care agency,

Community Home Care, Incorporated.
Q. Are you here every day of the week, or are you --
A. Yes, I am. Unless I go out to meetings off-site.
Q. And how often do you do that?
A. Probably twice a month, over to Providence.
Q. And you sort of went through, briefly, your resume as a practicing registered nurse. Where did you work as a staff nurse?
A. Newton Wellesley Hospital, in Massachusetts. New Britain General in New Britain, Connecticut. Bristol Hospital in Bristol, Connecticut. And John Dempsey Hospital in Farmington, Connecticut.
Q. And when you were a nurse manager, where did you practice?
A. Bristol Hospital.
MR. HICKERNELL: That's all the questions I have. Thank you.
MR. CAHILLANE: Just with respect to her background, I do have one question.
MS. BUTLER: Mm-hmm.

REDIRECT EXAMINATION BY MR. CAHILLANE:

Q. Do you hold any leadership positions in nursing?
A. Yes, I do. I'm currently the president of the Connecticut Nurses Association.
MR. CAHILLANE: Okay.
MS. BUTLER: The equivalent of the Massachusetts Nursing Association?
THE WITNESS: No. The Massachusetts Nursing Association --
MS. BUTLER: Which is a union.
THE WITNESS: That's right. They --
MS. BUTLER: So that's why I was wondering.
THE WITNESS: They separated from the American Nurses Organization, which is the national organization. Each of the states belong to the national organization, but Massachusetts and California no longer belong to the American Nurses Association.
MS. BUTLER: Okay. I guess what I was confused about was whether the organization that you're president of is

IV

Page 66

bottle except where your IV tubing goes in. So she would have had to disconnect, keep this -- focus on keeping this totally sterile, which is hard. Alcohol your top of the bottle anytime you're going to reconnect or add something. Excuse me. With the needle. Take alcohol to clean it.

Put your needle in and deliver it. Let the medicine go in, in this case the 18 cc's of volume. She had 18 milligrams of the drug. Let it all go in there. Disconnect.

Which I'll just insert -- say, at this point, that we try to get out of using needles here whenever possible. And, in this case, by doing it this way, you would have to use the needle. And it's just general nursing practice nowadays, you try to avoid using needles, at whatever cost, because of sticks. So you cap off the needle so no one else sticks themselves.

So you added the medication. Then you would have to take this spike, which is the end of the -- one -- the other end of your IV tubing, and reinsert it into the bottle. And

Page 67

that just is a basic principle of nursing, that you don't ever want to spike and respike, for infection control purposes.

And then hang the bottle up and leave it there. And it's unused, so I'm baffled by why you added medication when you were -- according to Nancy's testimony, there was already enough in there. But -- so she added the medication, and it just stayed there, unused.

Q. Well, let me ask you. I mean, in terms of -- at least from -- from the record and from the prescription that was given, is there any apparent purpose for adding 18 milligrams to that bottle?

A. No apparent purpose because the order was already DC'd, so it shouldn't have been used in the first place. Plus, if she did administer the controlled -- the Ativan in this method, she documented in the computer already that she gave it at 8:00 and at 12:00. So as far as her accountability, her record of administration, it was already there. So there is no -- in my mind, any purpose why she would take it out and then add it to something that's

Page 68

not even being used.

Q. Okay. I think that's all with respect to the IV.

With respect to documentation, when the nurse has administered Ativan or morphine or any controlled substance, she's supposed to document it where?

A. I'm sorry, can you repeat the question.

Q. When the nurse has administered any controlled substance, she's supposed to document it where?

A. In the computer, in the medication administration record.

Q. Okay. And with respect to that computerized record, is there any part of that record that the nurses, and possibly physicians, would be relying on during their shift, in order to see what the patient has or should get?

A. Yes. There's, actually, two pieces. As Dr. Kasper pointed out, there is the medication administration record, which gets printed out during the night shift. And that is everything that's received, for example,

Page 69

yesterday. It gets printed out last night, in the middle of the night. The secretary or nurse will file it in the chart. So physicians and nurses can look at that medication administration record to see everything the patient received yesterday.

Now, as far as for today, there's two ways that a nurse will look up what's happening today. One, they can use that medication administration schedule. And that's, actually, kind of our -- the nurse coming on, that's their bible of what meds the patient is doing. And I shouldn't use the word "bible." Their schedule of drugs: When the patient -- what the patient is on and when they're due. And also on that med administration schedule is what the patient most recently received, by the previous shift.

MS. BUTLER: So the med administration schedule --

THE WITNESS: Yes.

MS. BUTLER: -- is synonymous with what we've sometimes called the flowchart? Or not.

JK

Page 70

THE WITNESS: No. We have the bedside flowchart, which in the ICU we use to document all our active, current vital signs, etc. Our assessment findings. So that's a bedside chart. And I know that confused you in the past. No, it's not always kept at the bedside. It's kept on a clipboard. So sometimes it's at the nurses' station, but many times the nurse carries that yellow flowsheet into the room to document things. Okay.

MS. BUTLER: Now, there's -- medication administration schedule is what? And what does that look like?

Q. (By Mr. Cahillane) Well, did you procure an example of one of these?

A. Yes. I took one -- printed one out.

Q. I'd ask if you can identify that as --

A. Yes. This is a medication --

Q. -- as an example of --

A. -- administration schedule.

Q. And --

MS. BUTLER: Well, I'm --

Page 71

MR. CAHILLANE: Yes, I'd like to enter that as a hospital exhibit.

MS. BUTLER: Hospital 17, perhaps?

MR. CAHILLANE: Yes, I believe that would be it.

MS. BUTLER: Okay. We're identifying this exhibit as Hospital No. 17. And this is something called the medication administration schedule. Shall we call it the MAS?

THE WITNESS: Yes.

(Hospital Exhibit 17, medication administration schedule, marked for identification)

Q. (By Mr. Cahillane) And is that, in fact, what it's referred to as, the MAS?

A. Yes. Nurses usually call it their med sheet.

Q. And this med sheet is printed out from the computer.

A. That is printed out from the computer -- usually by the secretary, if there's

Page 72

a secretary, or the nurse will have to print it out -- within the first hour of their shift. So, for example, I'm working days today at 7 a.m. Between 7:00 and 8:00 myself or the secretary will print out my med sheet, my medication administration schedule, for me for my shift. So I will know everything the patient is due. Like on page 1 of that it shows all the drugs, the dosages, when it was started. And, also, in this example, where it says date, June 12th, it shows the times that the patient is due for them. So, in this case, these are routine orders, scheduled drugs. And page 2 also has some more scheduled drugs.

Page 3 has the PRN order. And, in this case, many of the examples we are referring to are PRN orders.

Q. And I take it that the accuracy of the information on this MAS is dependent upon the accuracy of the information that has been put into the MAR computer.

A. One hundred -- totally. Right.

MS. BUTLER: Remind me again what "PRN" stands for.

Page 73

THE WITNESS: "PRN" stands for medications that are ordered by the doc that are given by the nurse only when the patient needs them, according to certain parameters.

MS. BUTLER: "Per required" --

THE WITNESS: Or "per RN," I've always assumed. I'm not really sure. A lot of these are Italian terms. The nurse makes the -- Italian, sorry. Latin.

MS. BUTLER: PRN -- well, just so it can stick in my unmedical mind, per patient request?

THE WITNESS: Sometimes it's request. Sometimes it's a need that the nurse determines. For example, a medication like -- we'll use this page. Page 3, the second one down, is the lorazepam, the Ativan. Or if we look at the third one down, Ativan. It's .5 milligrams P.O., by mouth, every four hours PRN. And it says down at the bottom there, "for anxiety." So, in other words, if someone is not anxious, we're going not